

## Utah Medicaid Prior Authorization Request for Hospice Services

<b>Hospice Provider Name:</b>	
<b>NPI Provider Number:</b>	
<b>Initial Hospice Admission Date:</b> (No matter the funding source)	
<b>Is the client Medicaid eligible upon initial admission?</b>	<input type="checkbox"/> <b>Yes</b> (Submit only this form to Medicaid within five days. If this form is not received timely, Medicaid will NOT reimburse for hospice services rendered prior to the date the PA request is received.)
	<input type="checkbox"/> <b>No</b> (Complete <u>this form</u> & attach a copy of the <u>initial care plan</u> but DO NOT submit anything to Medicaid until AFTER client becomes Medicaid eligible. Medicaid will then require both documents when determining post payment authorization up to 90 days retroactive.)
<b>Client's First Name:</b>	
<b>Client's Last Name:</b>	
<b>Medicaid ID Number:</b>	
<b>Social Security Number:</b>	
<b>Date of Birth:</b>	
<b>Diagnosis(es):</b>	
<b>Plan of Care:</b>	
<b>Physician:</b>	
<b>Hospice Contact Person:</b>	
<b>Contact Person Phone Number:</b>	
<b>Date Prior Authorization Request Submitted to Medicaid:</b>	
<b>Date of retro Medicaid eligibility:</b>	
<b>Medicare ID Number:</b>	
<b>Nursing Home Name:</b>	
<b>Medicaid Benefit Requested:</b>	Hospice ____ Room & Board ____ Other ____
<b>Prior Auth Effective Dates:</b>	_____ to _____ PA # _____
	_____ to _____ PA # _____
<b>Discharge Notice</b> <ul style="list-style-type: none"> <li>Call in to: 801-538-6634</li> <li>Or fax to: 801-536-0157</li> </ul>	<b>Date of death:</b> ____/____/____ <b>Date client revoked:</b> ____/____/____ (Send a copy of the revocation form signed by the client.)

Please note: This form is effective June 1, 2009. No other forms will be accepted after this date.